e-motion

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EDITORIAL

With the summer solstice rapidly approaching, the earth seems to have burst into a verdant flush of colour, '.....all in a rush with richness' (in the words of Gerard Manley Hopkins). It doesn't quite 'brush the descending blue' just now, for as I write this, a persistent, precipitant downfall tumbles from a descending blue-grey sky, which, nevertheless, brings the garden to life in a luminous array of green from my window. The last of the purple bluebells cling tenaciously to their fading colour and the giant poppies flaunt their scarlet petals in the long grass. The runner beans creep slowly up to find their fortune and the courgettes spread their leaves in anticipation of the summer sun. And as the greening of the earth offers us the vitality and fullness of life itself, so this bumper summer edition of e-motion comes into print, reflecting a range of expertise and a diversity of approach within the DMP community.

Tracey French, who works tirelessly for e-motion on behalf of ADMP members, has taken a much deserved short break, in order to celebrate her marriage to Simon. As well as congratulating Tracey and wishing her happiness in the years to come, I'd also like to take this opportunity to recognise Tracey's enormous contribution to ADMP. In past years Tracey has served as council member, editor for emotion (at times, single handed) and has organised workshops on behalf of the membership. So many thanks, Tracey, in appreciation of your time, energy, inspiration and generosity of spirit. This edition also welcomes ***Rosalind Howell*** to the editorial team, along with her keen and meticulous eye and we look forwards to an ongoing collaboration.

So in a climate of lush richness, this edition brings you some thought-provoking holiday reading, as well as news of forthcoming workshops and training. Firstly, in our News from ADMP council, ***Geoffery Unkovich*** offers us his thoughts as he steps aside from the auspicious position of chair of ADMP; a position he has held for the past two years. With thanks to Geoffery for his pro-active commitment and energy, which has served to further the professional standing of the Association as it continues to evolve and flow through the dynamic currents of change, particularly as we move towards HPC registration.

In this edition, two SrDMPs, ***Ellen Emmet*** and ***Natasha (Tasha) Colbert*** share articles based on the papers they submitted for senior registration. Ellen offers us a personal investigation into '*The Shape of Presence in the Therapy Encounter*', opening a unique window into her work as a therapist. She draws on a range of perspectives, such as Authentic Movement, developmental psychoanalytical theory and transpersonal psychology. As readers, we bear witness to the delicate and fragile empathic connections reflected in the '*sacred mirror*' of the therapeutic encounter. Ellen's writing gives voice to a deep somatic empathy in a complex process of energetic exchange, which shapes her therapeutic presence.

Tasha shares with us the beautiful and moving story of Sunita, a ten year old girl, providing a glimpse of their journey together in a sensitively crafted therapeutic encounter. Tasha grounds the encounter within a developmental framework, emphasising the significance of metaphor and a child centred approach in providing a context for therapeutic growth. She then brings Sunita's process of transformation to life in her crystal clear literary style, as Sunita is able to loosen her defences, process painful past experiences and internalise the riches of the therapeutic relationship.

'*When disabilities disappear'* is a collaborative article from ***Céline Butté*** and ***Geoffery Unkovich***, who explore '*Foundations of Dance Movement Psychotherapy Practice in Profound and Multiple Learning Disabilities*.' Their article offers us an insight into Céline and Geoffery's co-leading relationship in DMT groups with people who have PMLD. Framed in a social constructionist world-view, the article

addresses improvisation and creativity as channels for exploration, discovery and transformation within the DMP relationship. The article invites dialogue with others working in this field and I hope readers will be inspired to enter into a written discourse on working with clients who have PMLD.

Following our ongoing theme of the role of music in DMP in our *Dancing Dialogues* section, you will find an abstract summarizing an article by ***Zelide Jeppe,*** which is published in '*The Arts and Psychotherapy*' and can be accessed through ScienceDirect (see link). The article presents a therapeutic and artistic investigation into the interactive potential of movement and sound in DMP; a subject of interest to many practitioners.

If you peruse the section on workshops and conferences, you will find a wealth of inspiration on offer, including two exciting CDP workshops offered by ADMT, one addressing *supervisory perspectives* and another, *the body and ritual*. I would also like to draw your attention to a *correspondence tutorial in Movement Psychodiagnostic Inventory (MPI),* details of which can be found in our training section, sent to us by Susan Scarth; although the registration date is gone, Susan thought this would be of interest.

So this edition seems to reflect a whole range of experience and demonstrates some of the many facets of a lively professional community in all its diversity. In addition, I'd just like to remind members about the ***ADMP AGM***, to be held in June and urge you all to come, as it is valuable opportunity to meet with colleagues and to glean information of the workings of elected council members, who labour gallantly on our behalf.

Wishing you fruitful reading over the summer and may we be blessed with the descending blue of summer skies. For those you duly inspired to put pen to paper (or is it fingers to keys?), whether it's a brief response to an article you've read, or an inspired investigation into an aspect of your work, the autumn edition awaits your contribution.

Caroline Frizell *and the editorial team*

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Stepping aside!

Geoffery Unkovich – Chair ADMP UK 2007 - 2009

By the time you are reading this I may have taken several paces away from my temporary role as Chair of ADMP. My two year tenure has been an unparalleled experience which moved me psychologically, emotionally and most significantly physically. The 'holding' of professional expectations of others, and more significantly of my own, had a considerable effect on my physicality from which I have learnt a great deal about my habitual and familial behavioural character traits. I must thank all those who supported me during this time, as without them my mind and body would not have endured the enveloping tasks and responsibilities that this role encompasses. I thank them for their humour, advice, knowledge, curiosity, care, and resilience.

ADMP council members manage an extraordinary array of matters on the profession's behalf and I have been continually heartened by the collective knowledge and skills that have helped us move in a positive direction. A collective knowledge that considers the needs of the profession in the wider context, and which strives to safeguard our historical journey while embracing the journey yet to come.

Matters 'move' only through the pro-active approach of council members, and of ADMP members who support council in their work. I encourage all our members to engage pro-actively in their professional development as clinicians and as members of an ever-growing profession. From my experience as Chair I have read, heard, and discussed a wealth of topics that have strengthened my understanding of our profession in the wider context, this in turn has given me much greater clarity in my role as a psychotherapist. There are times when I have struggled to be seen and heard, times when I have just wanted to 'move' as a way of being seen and heard, and I guess this may be a reflection of our profession in the wider context.

I see the coming two years as a transition for us all as we move closer to HPC Registration and the State Regulation of our profession alongside the other Arts Therapies. I meet with HPC representatives in the coming weeks to discuss the process and timetable of events related to our registration, also the result of our Standards of proficiency consultation which they need to ratify, and to discuss our name protection. I will report back to council on the outcome of this meeting, and have agreed with council to continue my working relationship with HPC until it is more prudent to hand this over to the then Chair of ADMP.

The more imminent transitions we are about to make are the shift to embracing new guidelines for supervision and CPD, and the gradual process of change regarding our SrDMPs. These experienced practitioners will retain their role as supervisors and will appear in a new ADMP 'supervisor's register'. The work being undertaken on developing supervisor training for DMPs will continue over the coming year, and a new programme of DMP specific supervisor training should be available around September of 2010. As mentioned previously applications for current SrDMP registration close in August of this year. Applications submitted after this date will NOT be accepted. In the coming year anyone wishing to undertake supervisor training are advised to contact council in

the first instance, as they will offer advice on which current supervisor training programmes, with other Arts Therapies, are applicable.

The new website of admp.org.uk is almost complete. We will have switched over to this site by the AGM at the latest and will continue developing the site in consideration of the financial implications.

Council continue to work on the profession's behalf and I THANK them all for the wonderful work they do. I also thank all other members who have supported our efforts over the last two years – Tracey French, Caroline Frizell, Penelope Best, Sarah Holden, Professor Helen Payne, Dr Bonnie Meekums, Susan Scarth, and Dr Vicky Karkou. If I have omitted anyone then please do forgive me, you know that all efforts have been very much appreciated by me and council. I also wish to thank Andrew Clements, our administrator, who does an extraordinary amount of work for us all, and without whom I would have truly struggled to make sense of all that we have recently managed.

The Shape of Presence in the Therapy Encounter:
a personal investigation

By Ellen Emmet, SrRDMP

It is in the dynamic interplay and integration of experiential knowledge and theoretical formulations that my clinical stance finds its fluidity and its shape. In this paper I would like to articulate the founding interest that has shaped the development of my work from the very beginning, and continues to give it its ground and expression in my current practice. Through my love of dance, direct experience in Authentic Movement and within the conceptual frameworks of psychodynamics, developmental psychoanalytical theory and transpersonal psychology, as well as the spiritual tradition of non-dual wisdom, this core interest has been deeply nurtured and developed. Using examples, I will describe the themes, skills and theoretical concepts, which now structure my therapeutic meetings and will give examples of verbal and non-verbal interventions, which illustrate my understanding of the therapist's role. Ethical issues and supervision issues will also be addressed.

Presence Recognizing itself:

Reflecting upon the foundation of my work, I am brought back to early experiences as a dance therapist, working with autistic children. Then, I was repeatedly called to offer my presence to "pre-egoic" phenomena: In a session, a child would move in a random and disorganized way, eliciting in my own bodily experience a sense of fragmentation, and in my thinking a quality of disorientation and confusion. Abiding with the invitation to penetrate deeper into this unfamiliar movement experience, I would join the child's expression in any way that intuition suggested: mirroring a gesture, imitating a rhythm, using my voice, allowing my body to move without an agenda. Gradually, I would surrender any resistance and begin to welcome the discomfort of my own bodily and psychological reactions to the child's expression. In this moment-by-moment opening, I invariably noticed that the sense of a boundary between us had lost its apparent solidity and was replaced with a felt quality of spaciousness and permeability, yet without the merged quality characteristic of unconscious relationship. It seemed as if, all on its own, the efforts I had been making to "be present" and to empathize with the child, relaxed deeply, and eventually dissolved into a natural, less personal yet more intimate quality of being, within which the therapeutic relationship unfolded.

Within this larger space of witnessing, evidence of self-awareness would almost always manifest spontaneously in the child, as if they had never been met in that place before: our two pairs of eyes would meet in a glimpse of one shared recognition. For a fleeting moment, the child's movement would become organized: perhaps a hand reaching towards me, a clear sound uttered for my ears, a whole body impulse towards relationship and contact.

These moments touched me very deeply. They revealed my deep interest in the fundamental nature of "I" and "you" or what we call the self and other. Beyond the reaches of body, mind and perceptions and beyond the frame of developmental psychology and psychoanalytical theory, conventionally used as reference for working with such populations, there was the intuition that the true nature "I" and "you" was in fact a non-separate, open Consciousness that we all shared, knowingly or not.

This limitless witnessing presence, of which I felt glimpses, has become the most familiar and intimate experience of myself. It is inclusive of all expression and the ground and background for the specific verbal and non-verbal therapeutic interventions I chose.

In the case of an autistic child for example, I use specific tools sourced in developmental psychology in order to address very real problems of body cohesiveness, movement organization and ego development. For example, I may find myself kneeling over my patient who had found his/her way back to an infantile supine position on his/her back. Invariably here, the child gazes into my eyes with the undiscriminating and symbiotic quality of early infancy. As 'mother'/therapist, I then become 'the auxiliary ego' taking care of the child's infantile self-regulatory and homeostasis functions. (Mitchell and Black, 1996; Siegel, 1979.) With the child on his/her back, I may bend over him/her with his/her feet against my body. Pushing the child's knees towards his/her body invites an extension out which pushes me away. This action activates the proprioceptor system and the motility system. Simultaneously, the child feels the experience of controlling the relationship, towards and away. Typically, I engage the child as I come forward with a smile or a pleasing sound and when this is accompanied by eye contact for which the child is made to feel good about him or herself, the experience reaches a positive and perhaps corrective emotional level. Later, the interaction often involves the child reaching out to touch my face: a first expression of individuation. Later still, the child may begin to explore the space in various directions and ways, then returning back towards him or herself. During that time, games such as peek-a-boo, or chasing and catching using rhythmic interaction, can recapitulate earlier stages of both motor and emotional development.

The Sacred Mirror:

From the widest point of view, and based on my personal journey and studies in transpersonal psychology, I hold that while most psychological suffering is a manifestation of the fundamental misunderstanding that we are a limited consciousness, this misunderstanding shows up in a variety of symptoms at the level of the psyche and of the body. For most of us the awareness of this fundamental cause for suffering remains hidden, while the expressions of this experience of separation are so intimately fused with our physical, somatic and psychological identity that they also tend to lie outside awareness. This wounding comes in the form of trauma, addiction, stories, tensions in the body, sensations, negative emotions or movement patterns which perpetuate our belief and/or our deep feeling at the level of the psyche and the body of existence that we are a separate person, cut off from wholeness. Therefore, from this ultimate perspective, I see healing in psychotherapy as the gradual and natural relaxing of these knots held in our body and in our psyche and which seemingly limit what we deeply are. It takes the open mirroring presence of the therapeutic container and the safe and non-judging facilitation of the therapist to begin to see, welcome and investigate all the layers of defenses and behaviors and to recognize what their dissolution reveals. If a client's immediate experience is freed from its habitual modes of interpretation and he or she discovers that usual fixations and stories are not in fact at the core of their identity, a chance is given to experience and perhaps recognize the openness that underlies and permeates all phenomena. My role as a therapist is whenever and however possible, to facilitate and encourage the welcoming and experiencing of these deep layers. In this way, the therapeutic container comes to symbolize and express the transparency, clarity, warmth and safety of non-judging awareness. John Prendergast, a transpersonal psychotherapist, describes it as a sacred mirror, which can reflect back to the client his or her essential nature, "prior to and inclusive of all thoughts feelings and sensations". (Prendergast, 2004 p.3)

Empathic Connections; a welcoming presence:

While this ultimate level of experience is fundamentally the panacea of healing and pervades all that is said and done, at a relative level it is not enough. There are events in life, chronic or acute states of the body and psyche that warrant close attention and specific interventions. Because most of us as clients are involved or identified deeply with our suffering, we need to be met at the correct place and our experience needs to be welcomed and validated in ways which will foster safety and trust.

Underlying all my interventions is the deep intention to convey non-judgment, informed understanding, open curiosity and genuine meeting. Empathy, kinesthetic empathy and somatic counter-transference are the main tools that I use as I attend to my client(s).

When working individually with clients who have strong enough egos, this implies a capacity to turn awareness to the flow of my direct experience (bodily sensation, emotions and thoughts), in the presence of a client's feeling states, and verbal and non-verbal expression, while postponing labeling or interpretation. Sensations, emotions, symptoms, thoughts and layers of story are welcomed for what they are. Here, discrimination between what is "mine" and what is "yours", is an important part of the work. It delineates the boundaries of experience and minimizes the risk of merging with the client, in unconscious territories. In addition, it liberates a client from projection while refining an understanding of their character style. Thus, exploring counter-transference material in supervision is very helpful. For example, role playing my client and/or embodying their movement qualities, while giving myself the widest freedom to move and express any reaction held in my body can give me crucial insights and creative intuitions. Active imagination techniques with suggestion and facilitation from my supervisor have often been helpful: I sometimes visualize all my current clients sitting or standing in a room with me: as my supervisor asks me questions, I imagine who is sitting where and how, how close, how far…is this one moving or still; are some relating to each other, moving around the circle, present, absent, etc. Exploring this kind of imaginary scenario reveals hidden layers of feelings and projections, sometimes delivers new kinesthetic information about a client, and provides creative ideas for the course of treatment.

Early in my professional experience I worked with a severely anorexic adolescent girl. Her body was emaciated, and her capacity to feel sensations or express any emotion was severely compromised. Her mother, an alcoholic had recently died in a car crash. She had been a cold and absent caregiver: My client was busy controlling her instinctual life at all costs.

Initially my longing to nurture this client was based in an attempt to by-pass the intense discomfort of simply welcoming her as she was. I did not want to meet my client in this parched and barren place, and because of that, I was denying the therapy its true healing ground. In order to meet this client, I needed to use supervision to engage deeply with my somatic counter-transference, exploring once again my own personal history. In time I learnt to welcome my client more deeply in my body without merging with her negative somatic identity. I was better able then to offer her the tiny measures of understanding and warmth, which she could ingest, while remaining attuned to her true presence and deeply connected to my bodily experience.

The somatic and kinesthetic aspects of empathy allow me to come close to my client's world with all that I am. Clients sometimes describe kinesthetic and symbolic images, for example a client once described feeling as if she was holding poison in her throat. I may actively take that image into my own body in order to explore its effect with my client as well as how it may deliver its locked energy and healing wisdom.

Sometimes there is a kinesthetic impulse in a localized part of my body. This sensation may convey a direction for future exploration but also may express the invitation to remain and feel more deeply into the absence of aliveness, or holding pattern in that part of my client's body. For example when a client has shown great passivity in her lower body while describing feelings of disempowerment and victimization, I have felt tingling in my legs and feet and a desire to ground my energy down. Translating this kind of kinesthetic information into an immediate verbal or non-verbal intervention is not always necessary or helpful but the simple welcoming of this sensation may pave the way for future exploration.

Being a certified Laban Movement Analyst has been a great help in refining my understanding of a client's somatic, developmental, emotional and kinesthetic experience. Looking at missing effort qualities, pondering which states or drives they prefer, noticing the relationship between their posture and gestures, attending closely to the shape flow of their more subtle inner movement, to the planes and dimensions they seem to move in, to the size and shape of their kinesphere: these observations offer me insights into my clients' character style, their defense mechanisms, their sense of interpersonal boundaries, their developmental patterns and inter-subjective experiences.

When working with a group of psychiatric residents or a classroom of autistic children, empathy and somatic counter transference are used differently. For example in a dance therapy group with adult in-patients, I will attune to the mood of the group, and make references to events that may be impacting the unit as a whole. As we begin to move, I will choose music that may reflect the general feeling tone, but always with an intention to motivate movement and increase ego based awareness and time and space orientation. For this, using rhythm with a simple and clear up down beat seems to work. Usually, after a simple warm-up, I mirror the movements that I see around the circle, and eventually I will pick up on the clearest movement and offer it back to the whole group in the hopes of increasing a sense of synchrony in rhythm and/or quality and to gradually develop a collective movement theme. Calling out names, making and encouraging eye contact as much as possible, and remaining very grounded and spatially alert are ways to provide over-medicated clients with a stable ego reference, helping them locate their kinesthetic sense of self and begin to explore their environment.

With a group of 6 year-old autistic children, somatic counter-transference and kinesthetic empathy provide me with an accurate developmental assessment. Then a greater emphasis is given to a directive and structured leadership style, adapted to the developmental and behavioral needs of the group as a whole and individuals in particular. If the group is exploring the horizontal plane and patterns of oral movement, kinesthetic games involving coming in and out of the circle using a stretch band, can be both containing and allow for an experience of merging and differentiating. When a child is acting out or unable to participate, it is important for me to assess whether this is a behavioral issue which he can learn to master, or if it is a case of sensory overload or a developmental obstacle. Determining this sometimes takes time and requires the in-put of teachers and parent as well as the capacity to take on the child's movement in my own body, and join him or her in his kinesthetic and/or symbolic play.

Deep Empathy:

With a group exploring personal and transpersonal experience in Authentic Movement, empathy takes on yet another quality. In an attempt to encompass a transpersonal perspective, Tobin Hart, (2000) a writer in the field of transpersonal psychology, describes what he calls deep empathy. This refers to a direct knowing by which

the separation between subject and object is transcended. He writes: "Empathy refined still further involves neither objective observation nor seeing the world through the client's eyes, nor reacting to, nor fusing with, nor attuning to. Instead, the center of perception seems to occupy multiple perspectives simultaneously…one seems to become the field itself while maintaining awareness."

Witnessing in Authentic Movement, I often experience a shift of my felt experience. Sometimes this is known through a sense of my skin becoming more porous, or through the mass of my body losing its felt sense of density. Sometimes the somatic perception of different sensations in my body becomes more unified. And there is a felt recognition that these sensations are free floating in an unlimited space, like clouds in a vast blue sky. I often experience a shift in my experience of seeing: my gaze expands, or softens, and looking becomes effortless. I become less aware of edges and boundaries, equally perceiving matter and emptiness, light and darkness.

Witnessing in Authentic Movement, I often experience a shift in my felt experience of being located in space. In those moments, I seem to inhabit the "transpersonal field" between, in and all around witness and mover. In such moments the experience of knowing seems to coincide with the disappearance of a felt separation between subject and object: it is a direct knowing or understanding. "All knowledge that is constituted by an immediate encounter with the known object, rather than with a representation corresponding with it, falls under the rubric of knowledge by presence" (Khan, 2000, p.152).

Ethical Responsibility:

In exploring the intimate landscape of a client's experience as described above, I am constantly aware of the degree of intimacy this process evokes and the ethical responsibility that it carries in its wake. Early in a course of treatment, I assess a client's ego strength, sense of timing, sense of boundaries and degree of emotional autonomy. I tend to remain cautious with self-disclosure, never engage in dual-relationship and in general tend to allow a great deal of space for the client to initiate and determine the course of the therapy.

Whether I am attending to individual clients, or to an in-patient group, to a small autistic child or a collective of Authentic Movers exploring transpersonal phenomena, my intention is to hold the widest range of experience with and for my client(s). As Winnicott (1986) so brilliantly conceptualized, the clinical relationship is often a holding environment, in which the therapist offers good enough mothering. In time, the therapeutic space is experienced as secure and alive, allowing a client to explore fully that, which seems to impede growth and balance.

I remember working with Daniel, an 8 year-old boy struggling with violent angry outbursts at home. Family life was highly unstable with fighting parents, a borderline mother and an angry depressed father. Daniel was the identified patient and the family scapegoat. As a result, this little boy had poor self-esteem and his capacity for self-expression and inter-subjective and inter-personal relationship was compromised. At the sand tray, Daniel worked silently for months, sometimes with an undefined and passive quality, and sometimes a little more urgently with tiny bound gestures as he buried figures representing his family, in wet sand, over and over again. Daniel consistently ignored my attempts to show him that I was attending to his experience and tracking his activity. His spirit and liveliness remained tightly held in clenched fists and tight lips.

After some work in supervision to disentangle myself from the intense boredom and lack of motivation that I had been feeling with Daniel, I was able to open myself more fully to his presence and come much closer. Session

after session, I remained silently by his side, closely witnessing every gesture and attuning to his silence with my own very alert and lively silence. It soon became clear that I was becoming a safer presence in the room. Daniel began to look at me out of the corner of his eyes…eventually the tiny sounds I made to match his sand-tray play were acknowledged. As I attuned to his feelings of anger and frustration using and modulating my voice, I gradually gave him permission to express himself more freely, using a wider range of toys, scenarios, movements and sounds. Eventually, during the five years that we spent together, Daniel and I developed a warm and lively relationship in which he felt safe enough to verbalize his feelings. He explored his autonomy, developed a more positive self-image and began to differentiate himself from his family.

Theoretical Frameworks:

The specific theoretical framework and approach that I choose to work with is always elicited by the actual and direct embodied experience of the clinical encounter. Through my years of training and professional practice I have gained theoretical and practical understanding of various ways of working with clients verbally and non-verbally. As mentioned above, Laban Movement Analysis provides me with a tool for movement assessment and observation. My experience working with autistic children has given me a thorough experience of a developmental approach combining elements of psychoanalytical theory and object relations with movement play. Working with issues of addiction, depression, parenting difficulties, trauma, anxiety etc… has given me skills in somatic, and gestalt techniques, which have enriched my dance movement therapy skills. Intensive workshops with the Jungian analyst Marion Woodman, have taught me how to work with dreams and active imagination. Mentoring with Janet Adler in the discipline of Authentic Movement has refined my capacity to attend to direct experience personal and transpersonal while remaining completely open in the unknown.

At times I may use a blend of all these approaches, while at other times a theoretical framework will spontaneously impose itself in the course of a session.

For example, in a session working with a young woman, I was invited to witness a beautiful example of an archetypal narrative. This young woman, a wife and a new mother, had been struggling with her longing to remain the innocent, idealized, pure beauty and free spirit that she had so identified with as a child and young adult. I witness her movement:

I see you move through the space. You are walking and now almost skipping, your hands and arms moving lightly through the air, caressing the space around you. A light smile is on your face, as it turns upward as if to feel the warm caress of the sun. Witnessing you I feel free and care-free, my body light and ethereal, my world safe. And now I feel the delight of a mother as she beholds her virginal daughter. All around the air is clean, a gentle breeze, grass swaying here a butterfly and there a pretty flower…

And now I see your movement changing. In a slow transition I see your heels are digging into the ground, and rhythm appears to punctuate your movement. I see you stop and listen, your face serious. Your pelvis moves up and down, and I hear a deep guttural sound coming out of your body. Down you come on all fours, pounding the earth, rooting your pelvis. You are crying. I see you rolling onto your back, legs bent, slightly apart, open. You are crying as your pelvis moves up at times. Witnessing you here, I feel a descent into a deeper darker place within my body. As I see you descend, I feel my own descent and with it the pain and grief of surrender in my flesh. Witnessing you here I feel a surge of sexual and instinctual energy at the very root of my body. Witnessing you here I feel the sadness of a mother losing her daughter…

I recognized clearly the archetypal energies that are embedded in the myths of feminine descent. Once again, Jung's model of the psyche and his understanding of a collective unconscious deeply resonated with my experience of witnessing. Once again I was in the presence of a tangible experience of the collective unconscious, unfolding through specific archetypal movement and revealing universal themes of individual and collective longing to meet the Self.

I witnessed the delight and innocence of Kore as she indulged in her youthful innocent sauntering. And I clearly saw and felt her transition towards the underworld. Witnessing her descent I sensed the dark, primordial force of the instinctual realm ravishing this young innocent energy; I understood this archetypal initiation in my body, and felt the universal, open and generous wound, which it revealed. As I contemplated my client lying on the floor struggling and crying, I felt the despair of Demeter losing her daughter, and through this grief, I experienced and understood the deep, collective participatory nature of initiation. After that movement session, my client continued to explore her internalized split and journeyed into a more grounded and mature experience of her feminine nature.

Writing this paper has given me an opportunity to formulate layers of my experience as a dance movement therapist. It has confirmed the clear understanding that abiding in open and not knowing presence is the correct position for any therapeutic meeting. It has validated my deep sense that the only true healing agent is the welcoming of the moment-to-moment raw experience, divested of unnecessary or false interpretation. Most of us have been deeply conditioned to think and to feel ourselves as limited and separate from others and from the world. Yet if we investigate our direct experience we find that this is simply not so. We find for example that our witnessing presence is not confined to our physical body but that in fact our experience of a body appears in our witnessing presence. We find that our body is not a limited and solid object but a flow of sensation and feeling, appearing in the background of openness…The implications are vast and the formulations are important to allow our work as therapist to flow from this clear seeing, unobstructed.

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Sunita: *an example of Dance Movement Psychotherapy with children*

Natasha Colbert SrRDMP

Presented here is an edited version of the paper I wrote for my senior registration. While my practice with children has evolved since then, it may be of interest to other DMP's, particularly those who work with children. It is also an example of an integrative arts approach within DMP practice. Children move seamlessly between the different art media – from drawing a picture to banging a drum to dressing up as a character and telling a story. As any dance movement psychotherapist who works with children knows, we need to be flexible and responsive in our approach so that we can meet the child in their unique world and be able to understand what it is they are trying to express.

INTRODUCTION

Overview

The following case study reviews the therapy of Sunita*, a girl of ten years old. The therapy took place in a school setting, spanning one school year and consisting of thirty-two sessions on a weekly basis. This account of therapy is necessarily schematic and can only give a flavour of the many interactions I had with Sunita. It highlights through selected vignettes the different stages of therapy – beginning, middle and end – giving a sense of the development through time of the therapeutic relationship. It also shows how, through creativity and non-verbal expression, some painful past experiences were acknowledged and a range of emotions were explored and worked through. I reflect on some of the verbal and non-verbal interventions I made and Sunita's responses to these. Consideration is also given to the transference and counter-transference.

Before reviewing Sunita's therapy, I outline the context and my approach, as well as some background information on Sunita. I also discuss the theoretical framework informing my work with children.

Context

I am employed two days a week at a primary school in Tower Hamlets, where I provide individual therapy and group–work for children, and also offer a supervision service for teachers. Children are referred to me for a variety of reasons; most of the children I see have experienced some form of abuse or trauma, such as neglect, physical abuse, witnessing domestic violence, sudden bereavement or family breakdown.

The school is situated in the heart of the Bengali community, with 64% of children of Bengali origin. The level of poverty, deprivation and overcrowding in the home is high within this population. It is worth mentioning that this paper does not address cultural issues, however issues related to cultural difference were reflected upon in supervision.

THEORETICAL FRAMEWORK

Developmental Theory

My DMT practice with children is informed by my knowledge of developmental theory. The vital importance of a healthy bond developing between parent and child has been well documented and researched (Bowlby 1969,1988 Winnicott 1988,1989, Schore 1994, Stern 1977, 1985). The degree to which the mother is able to emotionally attune to her infant and attend to his or her needs has a significant impact on the child's developing character and mental health. For children who have not experienced sufficient emotional attunement due to an insecure attachment to their primary care-givers, therapy can offer the opportunity to experience being attended to, held in mind, and contained. It is this emotional attunement that is considered one of the major curative actions of child psychotherapy (Hunter 2001).

In Dance Movement Therapy, particular attention is given to the non-verbal attunement that takes place between therapist and client. This non-verbal attunement may take the form of beating the drum in time to the child's rhythmic stamping an example of cross-modal attunement (Stern 1985). Mirroring the rhythmic quality (tension flow) of the client's movement conveys empathy and mutual understanding, whilst adjusting to the shape of the client's body enhances trust and a feeling of confidence and support in the relationship (Kestenberg 1975, Loman and Merman 1996).

Much has been written about the value and importance of play to healthy child development. Through play the child is able to give symbolic expression to his or her thoughts and emotions. For children who have experienced abuse or trauma, the act of making a picture or telling a story in the sand tray gives safe emotional distance from the traumatic event (Sutherland 2000). It is through the creative act of playing that the child cognitively sorts experience as well as finds emotional expression, and it is this process that helps the child integrate and make sense of what has been happening in his or her particular world (Cattanach 1994).

Use of Metaphor

My approach involves working with the metaphors that the client brings through play. Bonnie Meekums in 2002 writes extensively on the value of the movement metaphor in DMT. She suggests that it is not always necessary to bring the creative process to a linguistic or conscious level, and that to do so may hinder its therapeutic value. Many children talk about their lives, including their traumatic experiences, within the metaphor of a story. So in working with children I often stay 'within the metaphor'. For instance I may overtly empathise with the character's feeling of aloneness rather than the child's feeling of aloneness. This indirect communication of responding with metaphor is a safe way of ensuring that I respect the child's defences, and may be particularly important so as to avoid, albeit unintentionally, exposing the child (Sutherland 2000).

There are, however, times when it feels appropriate to support the child to make connections between their symbolic story and their own life experiences and feelings, and the use of questions such as 'if you were one of the characters in the story who would you be?' or 'that bit when so and so… did that remind you of anything?' are useful for helping the child make connections and gain greater awareness and understanding of their feelings and experiences.

Child Centred

My approach is also informed by person-centred psychotherapy (Rogers 1980). My intention is to provide

a nurturing climate for the child in which creative expression and productive processes can emerge. I aim to bring my congruent presence, care, empathy, and non-judgemental attitude to the therapeutic relationship; I am there to encourage and reflect back the child's strengths, skills and unique qualities so that they can begin to own them for themselves.

Rationale for an Integrative Arts Approach

My decision to include other art and play activities alongside movement and dance is informed by the knowledge that we learn through all our senses, and that each art form provides a unique language of expression. For instance, we sometimes need to communicate and externalise inner visual pictures through art and play, inner and outer dialogues through drama, and emotional energies and atmospheres through movement and music (Sutherland 2000). This approach is influenced by literature from play and integrative arts therapies (Cattanach 2002, Sutherland 2000).

By offering multiple art modalities, the child is able to choose an art form that best communicates his/her emotional experiences. This may be different at different times, as this case study will demonstrate. In the treatment of trauma there is evidence to suggest that working with the somatic memory (stored in the limbic system of the brain), as well as engaging the visual cortex, is particularly effective in treating trauma (Lahad 2008). Therapy therefore that works with both embodied expression (movement, music drama) and visual pictures (drawing, picture cards, small world play) has been shown to lead to healthy reintegration of the traumatic memory (Lahad 2008).

STRUCTURE AND BOUNDARIES

Sessions take place in the therapy room and last forty-five minutes. I 'hold' the time for the child, counting down towards the end of the session. During the first session I make clear what is and what is not allowed within the session, in order to create a sense of safety and containment. I also explain the therapy's aims, and the limits of my confidentiality.

SUNITA

Background Information

Before working with Sunita I learnt that she had been placed on the Child Protection Register at the age of six weeks after her mother abandoned her in a duffle bag outside a hospital. She was returned to her mother and father and remained on the Child Protection Register along with her older sister and two younger brothers until the age of seven, when all four children were moved into foster care.

Over the years, evidence had been collected that the children had witnessed significant domestic violence between the parents. There was also evidence that Sunita and her siblings had suffered significant physical abuse by the mother. In addition, there was evidence of parental neglect and of the children suffering emotionally as a consequence of their traumatic experiences. From the family assessments it seemed Sunita's mother had undiagnosed mental health problems, and her father abused alcohol and substances.

After several months of living with foster carers, Sunita moved in with her grandparents, along with her older sister. The children see their parents on a supervised basis. Sunita's family are of Bangladeshi origin, and Sunita speaks Bengali at home.

Before starting therapy with Sunita, I met with her grandfather, to gain a picture of how Sunita was at home and to gain consent. I also met with the SENCO, Class Teacher and Learning Mentor to gain their views. They said that Sunita found it difficult to settle in class, was 'emotionally needy' and easily annoyed other children. She had no friends and was sometimes bullied by others in her class, and was also known to have hit other children.

Beginning Therapy

Sunita was ten when we first met. She talked quickly and seemed excited and apprehensive about what we would be doing together. She had been told by the Learning Mentor that I would be working with her, and that I 'helped children with their worries' and 'had lots of things to play with'. Once in the therapy room, she moved quickly around the room, her eyes darting from one thing to the next, picking up and putting down the different props. She seemed to need to explore the different areas of the room, finding it difficult to settle on one activity, and eventually choosing to create a story in the sand tray for the last six minutes. I sensed her anxiety, physically feeling this in my own solar plexus, and noticing that this was more intense than my usual feelings of apprehension at working with a new client.

The tension observed in Sunita's upper body gave a sense of having to 'hold it all together' and a feeling of underlying anxiety. Sunita's high energy and constant activity seemed to be a way of defending against painful thoughts and feelings.

The anxiety that I had felt in the counter transference and my observations of her movement patterns – such as Sunita's darting eyes, shallow breathing and bodily tension – also seemed to suggest a tendency towards hyper-arousal and a lack of internal safety, possibly caused by having suffered multiple traumatic experiences in early childhood and infancy (Herbert 2006). I was also aware that some of these anxious feelings could be associated with it being her first session, and meeting me for the first time.

From my early observations, Sunita did not seem to inhabit a sense of weight, suggesting a lack of grounding and an unclear sense of her own boundaries. My ideas therefore for possible movement interventions during therapy included activities that would encourage Sunita to experience grounding and a sense of stability.

The Role of Movement

It is useful to observe what is missing in the play of children who have experienced trauma, as it can give insight into the child's inner world (Sutherland 2000). In Sunita's play, I noticed early on the absence of physical play – or what is sometimes referred to as 'rough and tumble' play (Panksepp 2006). I made several interventions during the beginning and middle stages of therapy that invited movement activities. On each occasion, Sunita preferred to draw or engage in another creative arts activity. This reluctance to engage in physical play seemed to reflect a disconnection from her body, and the possible (unconscious) fear of being overwhelmed by strong feelings and sensations.

It also seemed to be important for Sunita to be in control of her experience in the session, possibly so as not to feel overwhelmed. As a result, she often ignored my verbal suggestions in the early stages of our work together. Therapy cannot work without the client's engagement and an established therapeutic alliance (Brown and Pedder 1979), so I respected her way of engaging in the therapy, and followed and responded to her initiations. By taking this child-led approach, Sunita was able to begin to find her way into embodied play through role-play and drama, and – towards the end of her therapy – into dance and movement.

Separation and Loss: The Rejected Baby

The theme of separation and loss reoccurred in different forms, and was worked with therapeutically throughout Sunita's therapy. The following extract is taken from my notes on session three and demonstrates the ways Sunita communicated her feelings associated with abandonment and separation – and my responses – during the early stage of therapy:

Sunita initiated acting out the following story…
The mum (played by Sunita) dresses the baby roughly, getting her ready to go to a party. After a long time the mum brings the baby milk for me to feed it. The mum then puts the baby on the floor; I remind her that we have five minutes left of the session. Sunita then kicks the baby out the way and says "She's not needed anymore". Sunita doesn't want to leave at the end of the session, I let her know the session has finished and wait by the door saying that 'it seems to be difficult to leave today'. She ignores me, making a card with both our names on it. She leaves 5 minutes after the end of the session.

Her action of kicking 'the baby' and her silent refusal to leave at the end of the session seemed to express her feeling of rage at being discarded and rejected – possibly associated with her traumatic experiences in early childhood and infancy – given that this response was apparently triggered by my announcement that the session was coming to an end. Taking this interaction to supervision, it was also suggested that she may have felt rejected by me at end of the session. I reflected on how I could have said something to this effect to help her gain some awareness of these feelings, while also wondering whether such an intervention could have felt exposing so early on in our relationship.

Safety and Containment

The following extract from session five suggests that in the early stages of therapy it was hard for Sunita to believe that I would turn up the following week:

As the end of the session was approaching, I gave Sunita a five minute time check. In response her actions accelerated and her breath quickened, picking up on her feelings of anxiety, I wondered out loud: "Perhaps you're worried I won't turn up next week". At this Sunita responded "You are going to take me next week, ***aren't you****" I reassured her that I would. I also let her know that I 'held her in mind' in-between sessions. Sunita listened and then started singing something about 'being at sea'. She made a boat out of the soft play and asked me to rock her. Rocking her gently, I had a sense of adjusting my body position in order to keep her safe and make sure she didn't fall off. Sunita closed her eyes, her body relaxed and she began to breathe deeply.*

The metaphor of 'being at sea' perhaps suggested a sense of feeling overwhelmed by difficult emotions. Her act of 'making a boat' seemed to be about seeking protection and safety, which she then expressed further by seeking my comfort and containment. Reflecting on the movement interaction between us, my maternal counter-transference here was of containing and caring for her, expressed through creating a containing shape with my own body. This sense of metaphorical 'holding' is symbolic of the mother's literal holding of her baby that helps the infant develop a sense of internal safety (Winnicott 1989).

The non-verbal interaction of rocking her mirrors the sucking rhythm: the first developmental rhythm that soothes the baby, helping him feel safe and secure (Loman 1998, Kestenberg 1975). By attuning to the shape flow and tension flow, I attended non-verbally to her needs in the moment. Sunita's response was to relax her body, giving into allowing herself to be being comforted and soothed, reflecting her growing trust in the relationship.

Over time, the verbal interventions that acknowledged Sunita's feelings as we approached the end of our sessions – such as acknowledging that it was hard to end and was natural to feel anxious at this time – seemed to also help her make this transition. As our work progressed, Sunita became more aware of her own feelings about the separation and was able to verbalise them herself, saying things such as *"It's hard", "I don't want to go"* and *"It hurts"*.

Dealing with breaks in the therapy

As a way of supporting her with the difficult feelings associated with separating, it felt important to encourage a sense of continuity from one session to the next. For instance, early on in our work together Sunita made a diary that I suggested we keep in her folder and put safely in my cupboard each week. As we approached the Christmas break (after working together for ten sessions), Sunita wanted to make another diary to take with her. I encouraged this, as it seemed important for Sunita to have something tangible to remind her of the therapeutic space during the break, as if this created a link to me during the separation. We talked about how she could write down her thoughts, feelings, and even dreams in her diary. During therapy the book became an important 'object' for Sunita that she added to between sessions and during holidays. She told me that she kept it in a *"special cupboard"* at home.

The diary seemed to act as a 'transitional object' for Sunita, bridging the time between sessions and helping her to manage her feelings about the separation (Winnicott 1989). Separation from me seemed particularly difficult for Sunita, perhaps because the gaps between the sessions seemed to remind her of the separation from her parent, of whom she spoke often. In the counter transference I felt the pain of this loss and the longing. With this in mind it also felt important to tell her that I thought about her between sessions. The process of being attended to and held in mind is in itself an emotionally containing experience (Hunter 2001).

The use of the diary as a transitional object showed Sunita's ability to find a way to manage some of the painful feelings around separation; and her special cupboard, where she kept it, perhaps indicated her ability to create some symbolic representation of me, where things are looked after and kept safe.

Middle Stage of Therapy: the developing therapeutic relationship

By session ten, it seemed Sunita had developed a positive attachment to me, expressed through her play: acting out and developing a drama story over several sessions that depicted a loving bond between mother and daughter. This story often involved the mother's delight in seeing her child, giving hugs and playing 'peek-a-boo' games together. This was a noticeable development into embodied play, seeming to reflect an increased sense of safety and ease in her body.

It seemed that these movement games reflected a growing confidence and trust in my continued presence, and that I could be 'lost and then found'. Through this drama story, I was depicted as the 'good mother', providing her breakfast, giving her hugs and generally being positive towards her. This was not difficult to do as I felt genuine positive feelings towards Sunita, who seemed to be able to get some of her needs for warmth, affection and nurturing met through these interactions.

This growing sense of safety and trust in the relationship seemed to facilitate more negative feelings being expressed, often directed through the transference. At times she ignored my presence for long periods of time or ignored my personal space, for instance dressing me up in clothes in a way that felt intrusive. In the counter-transference I felt mistrusted, ignored or intruded upon. The negative transference and my counter reactions

gave me insight into her experience of relationships and in particular her experience of her body boundaries being violated, most likely through the abuse she had suffered.

My understanding of the negative transference is informed by literature on trauma and attachment – it is likely that Sunita's attachment to her primary care givers was insecure, due to experiencing her mother as a source of danger and being emotionally neglected by both parents; this insecure attachment leads to difficulty in trusting others and can be re-enacted in the transference (Bowlby 1969, Rothschild 2000).

The Broken Cake

I was aware that Sunita had been known at school to have rage outbursts and in session eleven Sunita brought, albeit unconsciously, this intense feeling to her therapy:

" I got out the (clay) cake that she had made the previous week, noticing a crack in it. Sunita took the rolling pin and smashed the cake repeatedly until it was broken into pieces…at the end of the session I suggested we keep the pieces and that I look after them in my cupboard, Sunita agreed to this. I carefully put them away in my cupboard."

I reflected on this sudden outburst after the session: the cake had cracked in my care; perhaps this had made Sunita feel that, like her mother, I could not contain her properly, resulting in her outburst of rage. By connecting destructively with another object, Sunita was projecting her pain outwards, which in the past had resulted in aggressive outbursts towards other children**.** It seemed that this was the only way she was able to 'ground' herself.

I was aware that as a result of insecure attachment issues it was likely that Sunita may not have learned healthy affect regulation through containing and reliable interactions with primary caregivers (Herbert 2006, Schore 1994). My verbal and non-verbal intervention of keeping the broken pieces was a way to symbolically communicate to her that her feelings could be contained and cared for in therapy.

The following week I got out the broken pieces and we looked at them together. Sunita seemed surprised to see it again and I said something about it being an "an important piece of work". Two weeks later, Sunita made another cake out of clay, and then asked to see her broken cake. She then placed some of the broken pieces carefully on to the whole cake. I commented that it was clever how she had created something new, and brought the two pieces of work together. She was very engaged in this activity and seemed calm and focused. My intervention of looking after the broken pieces of the cake perhaps gave Sunita the message that her rage – and the parts of her that felt 'broken' – were accepted and contained. As Sutherland suggests: "Having a feeling that has been experienced as too dangerous in the past, met with understanding, can be an immense relief. At last feelings have been accepted and normalised" (2003: 54).

Broken Heart Song

The theme of 'broken into pieces' was further explored through our work together in various ways, for instance through the medium of song in session seventeen.

Sunita asked to see her broken cake. As we looked at it together she commented on the broken pieces…she then picked up the small harp strumming it to herself. She stood up on a chair, saying she wanted to sing. She began to sing freely "Everywhere I go, there are hearts that are broken into pieces. I feel heartbroken. I don't know

what to do"…she continued to sing about how she had felt so alone, I hummed along matching the rhythm and tone of her song.

After a while Sunita asked me to sing, I sang my response that included "I'm sorry it's so hard, I'm sorry your heart was broken". We continued to sing together, singing one verse each – her experience, then my response until it reached a natural pause. Sunita said she wanted to write the song down, including what we had both sang. She then got down from the chair and we sat down next to one another shaping her body into mine, and initiating singing the song again several times – together and on her own.

She commented that it was a sad song, and then tried out singing a 'rock version' with an angry expression. When she had finished I said that this was an important song and that she had been brave to express her sad and angry feelings, and that these feelings were welcome here…she smiled and said she wanted to keep it in her folder.

I felt very moved by this interaction. My spontaneous response to her song was a way of letting her know that her feelings of sadness, loneliness and anger were heard and accepted. Reflecting on the body-positioning and shaping aspects of this interaction, it seemed that Sunita needed to position herself above me (by standing on a chair) to be able to begin this song, perhaps to feel that she had control and power over expressing these painful feelings, and a safe enough distance from me so as not to feel overwhelmed. The movement of getting down from the chair and sitting next to and shaping her body into me seems to suggest that she then felt safe enough to be in closer proximity and at the same level, seeking closeness and comfort from me. Through singing, Sunita breathed more deeply, connecting with the quality of flow. Flow is often associated with the expression or control of feelings (Bloom 2006). Through her song, Sunita was able to connect and express her more tender feelings.

Relating this extract to the literature on the effects of early emotional neglect, the metaphor of 'broken into pieces' – first expressed through the breaking of the cake and then through the song – reflects something of Sunita's internal world and the 'unthinkable anxiety' experienced when there is a lack of reliable maternal holding and early emotional deprivation, leading to the feeling of 'going to pieces' (Winnicott 1988). The above extract perhaps demonstrates the reparative experience that therapy can offer, where the client can express feelings that are overwhelming to them in a space where they feel held and contained.

I have noticed that often after such an opening and transforming experience, the client needs to 'pull back' in the following session to a more concrete and conscious state, possibly out of a need to integrate the experience. Meekums (2002) suggests that during this middle phase of therapy the client dips in and out of active work; it is not possible to keep up the intensity brought by the descent into the unconscious. Sunita did this by bringing her schoolwork to the next session and resisting at first the activities on offer. In the following two sessions, however, Sunita revisited *"my favourite song"* as she called it, using different rhythms to express a range of feelings. Sunita also told me that the song made her feel *"calm inside"*.

Preparing for the Ending

I was aware that the ending of therapy would be particularly difficult for Sunita to process given her series of traumatic experiences in early childhood and infancy involving loss and separation. As Herbert (2006) suggests, traumatic material is often fragmented or only partially accessible, thus making it difficult for feelings to be communicated and worked through.

Fragments of traumatic material did indeed surface during the later stage of therapy, such as Sunita describing in detail some of the abuse by her mother. Angry feelings were directed towards me on a couple of occasions through dramatic play, in which I found myself being 'told off' or told I had 'done bad things'. While these feelings seemed to be connected to her mother, expressed through the transference, it is likely that she was also expressing the anger she felt towards me for imposing an end to her therapy, and the feelings of rejection associated with this loss.

The disclosures of past abuse, and Sunita's sharing more about the difficulties at home, seemed like a cry for help, expressing her fears around the loss of support that would be caused by therapy ending. These feelings were further compounded by the fact that she was also facing the loss of her primary school.

To support Sunita to process and prepare for the ending of therapy I began to name and count down the imminent ending ten weeks in advance. I initiated looking back on the journey we had made together, I reminded her of all the hard work she had done in therapy: her courage in being able to show painful feelings, as well as her creative talents. During these conversations, Sunita reflected that she used to think that she was "*no good at anything*" but that now she realised that she was "*good at lots of things*", and knew that she was creative. She wrote an entry in her diary: "*Tasha has made me feel great inside my heart*". Sunita's increase in self-worth was also noticed by her teachers and learning mentor, who told me that she didn't "fuss like she used to" and seemed more confident in herself.

Transition

The last stage of therapy was also a time of looking forward, and thinking together about the future transition to secondary school. Sunita expressed her worries about the change of schools, in particular her fear of being bullied. Her teachers and other staff supporting Sunita, including myself, were concerned about her difficulty with peer relationships and agreed that Sunita would need support with the transition to secondary school.

Taking into consideration the trauma and abuse that Sunita had suffered, and the damaging effect this had had on her emotional and social development, I discussed in supervision the possibility of referring her to the play therapist at secondary school. I was aware that I did not want this to confuse the ending of our work together, and thought carefully about the timing of introducing Sunita to the play therapist. I was also aware that handing her over to another therapist could bring up painful feelings associated with the trauma of being abruptly removed from her parents by social services and being placed in foster care. I therefore arranged a meeting between Sunita and the play therapist several weeks before the ending of her therapy with me, so that there would be time to process this new person coming into her life.

It seemed important to let her know that, if I could, I would continue to work with her when she went to secondary school, but that in reality this was not possible, and that the ending would be likely to be difficult for both of us. I also made it clear that it was ultimately her choice whether she saw the therapist at secondary school, and not a decision that was being imposed upon her.

THE ENDING

Creative Movement

It wasn't until session thirty that Sunita accepted my suggestion to move together as a way of warming up at the beginning of the session. It seemed that this engagement with movement reflected a greater ease and sense of safety, both in her own body and in the therapeutic relationship.

As a way into warm-up I suggested we move 'in our own bubble', to encourage awareness of her own kinesphere before relating with one another. I then invited 'reaching out beyond our bubbles' out into the larger space. Sunita began moving in 'slow motion' and I mirrored her movement…after a while of exploring our lightness, "being in space" as Sunita called it, I suggested the opposite, feeling our weight and heaviness. At this, Sunita walked around the room, stamping her feet. I suggested that we could let our arms join in too and Sunita began punching her arms in time with the stamping, with a smile on her face.

My intervention of suggesting we move in our kinesphere was intended to support Sunita in gaining awareness of her personal space, something I had observed she seemed to lack. My suggestion of exploring the different qualities of weight was to help her to inhabit a sense of weight, and experience the difference between feeling light and feeling grounded. Her use of firm weight in stamping and punching the air seemed to reflect a connection to her emotional strength and her potential to be assertive.

Our movement interaction during this session continued…

We played with moving between light and firm weight, moving alongside one another. Sunita suggested we mirror one another, which we did and then I suggested we see what it was like to move differently from one another…. After some minutes I said "Let's see what its like to move with our backs to one another, still feeling the connection between us". After a while of moving in silence feeling this connection, Sunita said softly "I can't see you, but I can still feel you"…acknowledging this I said that I too couldn't see her but could feel her presence, and that it was a bit like when we wouldn't see one another anymore but would still think about each other.

It seemed that by working with the theme of separation non-verbally, Sunita was able to gain some embodied awareness of how it might feel to not see me anymore. My intervention was intended to support the idea that her positive experience of therapy could be an inner resource beyond the end of our sessions together.

The Last Session

As a way to mark the ending, Sunita asked to have "a party", requesting that I bring some relaxing music and food. Putting some music on, Sunita suggested we dance with scarves. Sunita's dance incorporated opening gestures and flowing movements through space, and found completion with a slow bow to one another, as if showing our appreciation and respect for one another.

I asked Sunita what she would remember about therapy. She named the cakes she had made, her song, dancing together and all the fun we had had together. As I carefully wrapped up her artwork so she could take this with her, we admired each piece of work, including a cake with a 'world' on top that she had made in the last few weeks. Sunita called this '*Tasha and Sunita's World'*. This final piece of work seemed to be a tangible representation of the positive therapeutic relationship, in a form that she could take with her.

Towards the end of the session Sunita expressed some anger about her therapy ending, saying that she found it "*very unfair"*. I was able to empathise with these difficult feelings, which then gave way to a feeling of sadness. In saying goodbye she said: "*You've been like a mum to me*". Containing my own sadness about our work ending, I was able to share how much I had enjoyed working with her, and how I would always remember our work together.

FURTHER REFLECTIONS

A gentle and flexible approach was needed in working with Sunita, given the multiple traumas she had experienced and my awareness of the risk of re-traumatisation through inappropriate interventions (Herbert 2006). Through the course of therapy Sunita seemed to be able to symbolically externalise a range of emotions and experiences – through the creative mediums of movement, music, drama, art and clay – without being overwhelmed.

Giving Sunita choice and control during her therapy was an important intervention which resulted in us not working directly with creative movement and dance until the later stages of therapy. As Rothschild (2000) suggests, giving choice and control to the client is particularly important for people who have experienced abuse and trauma, as trauma is something that is experienced as being imposed from the outside.

Reflecting on Sunita's development over the course of therapy, there were noticeable changes from my initial movement observations made after the first session: the initial tension in her upper body that caused her breathing to be shallow gave the sense that she was 'holding it all together'; through the therapeutic relationship she was able to experience being held 'from the outside' which seemed to enable her to let go into deeper breathing, and allow her to access the quality of freer flow and communication of tender feelings, given form through song and expressive movement.

Through the movement work she began to be able to inhabit a sense of weight across the range from light to firm in quality, connecting to grounding and stability - an important distinction from using weight as a destructive force as seen through the smashing of the cake. It seemed that Sunita's expression of unconscious rage – and having these feelings contained symbolically through my looking after the broken pieces – led to her being able to safely reflect on the part of her that felt 'broken', expressed through her song. She then seemed to find a way to integrate a sense of being both 'broken' and 'whole' through physically bringing together the broken and whole cake. As trust developed, Sunita brought some of her most vulnerable and fragile parts of herself to therapy.

Through movement work, Sunita was able to embody the qualities of weight, flow, space and time, and begin to gain a sense of her personal space and the space beyond her kinesphere. Her choice to engage in creative movement with me seemed to reflect a greater ease and sense of safety in her own body. These movement observations suggest that therapy provided Sunita with an increased range of options and choices for relating.

Although the ending of therapy felt premature, it did seem to provide Sunita with a different experience of endings from the abrupt and traumatic one she had gone through in being taken into foster care. Preparing and thinking together about the ending was crucial, as was acknowledging the sad and angry feelings associated with the loss.

The therapeutic relationship seemed to provide Sunita with the experience of being attended to, held in mind and contained. It is likely that this experience of 'feeling that she mattered to someone' contributed to her increased self-worth, noticed by those working with her and acknowledged by Sunita herself. As Hughes suggests "Without attachment relationships a child cannot experience herself as being special and worthwhile" (1998).

Some of the developments Sunita made in her therapy, were not yet experienced in her relationships with her peers. In referring Sunita for further therapy, my hopes were that she would be supported to build on the strengths and resources she developed through our work together.

It has been suggested that for clients who have experienced multiple traumas in childhood, the therapeutic relationship is often the most important component (Rothschild 2000). In the case of Sunita, it seemed that her attachment to me provided a positive experience of relating, such as the enjoyment of being with another. As Rothschild suggests: "When successful, the positive attachment to the therapist can change habituated avoidance or fear of interpersonal relationships into desire for healthy contacts" (2000:82)

**A pseudonym is used*

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Foundations of Dance Movement Psychotherapy practice in Profound and Multiple Learning Disabilities

'When disabilities disappear'

Céline Butté & Geoffery Unkovich

Introduction

This article discusses the mode of practice co-constructed by two Dance Movement Psychotherapists for co-facilitating long-term Dance Movement Psychotherapy (DMP) sessions with a closed group of adults in a Learning Disability day centre for a London Primary Care Trust. We present our Foundations of Practice with clients diagnosed with Profound and Multiple Learning Disabilities (PMLD) and an ethos for group-work (Shotter 1994: p39) established over time. We view this as the beginning of our journey in writing about our professional relationship with this client group, and we hope that it will stimulate others to contribute to the writing and development of practice-based-evidence for working with adults with Profound and Multiple Learning Disabilities.

Coming from a place of curiosity regarding our practice with non-verbal clients, we have reflected on our own perceived learning and physical disabilities. This reflection has been a means for us to recognise the roots of our practice as co-working DMPs with adults with PMLD. In this paper, we bring to light and put some words on what may be one of the most non-verbal psychotherapeutic relationships. We acknowledge how our clients may be perceived in society, and the implication of having a PMLD diagnosis. We name the dichotomy between the subjectivity and authority inherent to our role as DMPs, and our intention to be curious and open to our clients' unique way of expressing themselves. Recognising these positions and locating our practice within a social constructionist framework we identify tools and techniques which inform our work. Movement improvisation offers us a means to ground our practice within current dance and psychotherapeutic theory. Considering breath as a vital and natural life giving experience inherent to all beings, we reflect on our roles as DMPs with this client group, particularly on the therapist's choices in his/her relationship with adults with PMLD.

The clients considered in this paper are adults diagnosed with Profound and Multiple Learning Disabilities, individuals who hold multiple complex diagnoses; involving neurological, physiological and physical impairment together with mental health diagnosis.

An Assumption

Sociologically we view the body as inherent to self-identity, and to the construction of social inequalities (Shilling cited in Shaw 2003: p19) that may have caused clients to shrink or contract away from the world, leading them to inhibited self-expression. We are mindful that our view of the body as a 'reservoir of subjective phenomena' (Shaw 2003: p20) may be corrupted with values and beliefs about what the human body is capable of expressing (Bonefant: p120).

'Expressions generate impressions. We express ourselves by impressing ourselves on the world.

> The world expresses itself by impressing us. In this exchange, we are ourselves and we become somebody' (Keleman 1975: p81).

Profound and Multiple Learning Disabilities

The diagnosis of Profound and Multiple Learning Disabilities (PMLD) is a subgroup of a large Learning Disabilities umbrella which encompasses Mild, Moderate and Profound Learning Disabilities. There are a number of organisations that provide a definition of PMLD (i.e the British Institute of Learning Disability- BILD, the World Health Organisation, and Local Authorities) which we recommend the reader consults if she/he has an interest in working with this client group. In this article, we use the definition provided by the PMLDNetwork as it is the most up-to-date definition currently available and reflects the complexity inherent to being diagnosed with PMLD.

First and foremost, the PMLDNetwork invites us to recognise that children and adults with PMLD 'are, like everyone else, unique individuals' (PMLDNetwork, 2009). The Network emphasizes that 'at the moment, the needs and rights of people with profound and multiple learning disabilities are frequently neglected' (ibid).

They also remind us that:

> 'while many barriers can be challenged and even removed, ultimately, we cannot change the nature of people's disability. In doing so, we are not being discriminatory, rather we are respecting people's differences and valuing them for who they are.' (ibid)

Focussing on the clinical aspect of the diagnosis the PMLDNetwork add that: 'children and adults with PMLD have more than one disability, the most significant of which is a profound learning disability. All people who have PMLD will have great difficulty communicating' (ibid). This pertains to 'communicating' as we understand it in the forms of communication that are valued and taken for granted in our current society: the use of verbal communication.

Current research tells us that there is a lack of recognition that individuals with PMLD are a marginalised client group whose needs are different from those with Mild and/or Moderate LD (Carnaby and Cambridge 2002, Dobson et al. 2004) due to the complex interplay between communication challenges, physical and sometimes mental health problems. Sheehy and Nind suggest we consider children and adults with PMLD as people 'having substantial barriers to learning and participation in community life, which arise from interaction between organic impairments and an often unresponsive and unsupportive environment' (Sheehy and Nind 2005, Butté 2008).

We agree with Burr that disability is a function of the environment in which people are forced to live and not solely a quality that belongs to them as individuals (Burr 2004: p38). From this perspective disability is not only socially created, but also sustained by social structures that often serve the interests of dominant groups in society (Burr 2004: p123). Many adults with PMLD have been institutionalised (Valuing People Now 2009: p27), which can lead to isolation, self-harm or obsessive movements (Sherborne 2001: p91). These are historical facts we take into account in our practice as Dance Movement Psychotherapists with this client group.

Social Constructionist World-View

Concepts of mutual influence are integral to our co-working relationship as psychotherapists, in which our individual realities contribute to the co-construction of sustainable ways of interacting with others, and for the negotiation of culturally accepted ways of being (Cecchin 1992: p93). We acknowledge that we do 'not exist independently of society' but we, and our relationships, are apparent through our social interactions (Burr 2004:

p193). Within the DMP relationship with individuals diagnosed with PMLD, our clients employ movement interactions such as turn-taking, sharing, or imitation and mirroring; these movement interactions with our clients, and with each other, are a 'conversation of gestures' (Burr 2004: p193) in which the therapeutic story unfolds.

> 'When we interact through a conversation of gestures and later through language, we know that a gesture or word has the same meaning for others as it has for us. This gives us access to the minds of others; we can imagine the meaning that our actions have for others because of the meaning they have for us. And this gives us choice' (Burr 2004: p194).

This joint action (Shotter 1994: p38) is a dance in which we are constantly and subtly responding to each other's sounds, rhythm, posture or gesture; we do not perceive this co-constructed dance of 'unpredictable outcomes' to be the result of any individual's prior intentions (Shotter 1994: p39).

Our role presents a creative friction for us: on the one hand we honour a position of co-construction and mutual influence in the therapeutic relationship with clients, and on the other hand, we hold contracted positions of authority as therapists in an NHS service. Realistically, we have authority insofar as that authority is invested in us by the Trust we work for to provide a service to our clients. The realist perspective sees the world from a 'top-down' view which privileges the notion of 'power' coming from above (Burr 2004: p102). This is our dichotomy; the friction between embodying a position of mutual influence with clients versus our position of authority as employees of the trust.

As Dance Movement Psychotherapists we consider movement, sound and vocal expression as the language of discourse and communication; therefore we apply social constructionist theories on 'verbal' language and discourse to non-verbal communication in a psychotherapeutic framework. This position provides us with a co-constructed 'set of concepts, images, metaphors, ways of speaking, self-narratives and so on that we take on as our own' (Burr 2004: p119). The ever-changing nature of the creative personal process means that our subjective positions constantly change as we negotiate our social interactions (Shotter 1994: p120).

Our belief encompasses the continuous unfolding in the creative therapeutic space, and in the on-going creative process of mutual influence. Our therapeutic relationships are enriched by this social-constructionist world-view which enables us to consider the dynamic process of interactions that form through communication pathways (including the use of sounds, movement, words).

Re-covery

Frequent immersion in the non-verbal world of our clients, attuning to their movement discourse, and experientially inhabiting the emotive content of that discourse, can result in dissociation of oneself as an individual. The impact of this immersion and the infinitesimal responses of the body to all that we experience, may mean that we therapists become mis-attuned to the multi-dimensional inhabitation of the physical being that is self (Unkovich 2009: p7). Taking time to physically and verbally de-brief at the end of the day and to 're-claim' our bodies enables a 'psychological and physical re-covery which allows restoration and ownership' (Unkovich 2009: p8) of our first person positions as physical beings; listening to our own needs and letting go of holding the therapeutic space for others. This re-covery allows our body and mind to be continually cleansed and so more receptive to the client experience without fear of future collapse or exhaustion through inhabiting our clients' world.

Improvisation and Contact Improvisation

We have a lifetime's experience of dance and the body moving; confident with the language of improvisation we implicitly trust one another's dances as they unfold within sessions. Our continual curiosity with the moving body always informs our practice, and having been professional dancers for many years' means that we are very knowledgeable about the functioning of the body.

DMP training triggered a shift in our understanding of the body moving and of the intention behind creative expression through movement; the shift from an aesthetic focus to an embodied experience. The social-constructionist perspective means that we embrace positions of curiosity within the therapeutic relationship; creating a space within which our existing understanding of the body can be challenged and thus evolves, and within which a shift of position from first to third person is accessible to all present in the therapy session.

One of the main movement forms we use in our DMP practice is improvisation. This movement/dance form demands our moment-by-moment responses, which includes the sensations, emotions, ideas, and fantasies of the moment which are present in our internal environment. When we improvise, our attention is anchored firmly in the here and now. There are no judgements about what is good or bad, and there are no mistakes. Everything, whether it arises on the level of soma or psyche, is used as material to create and communicate (Halprin 2003: p119). Within an improvisatory framework interaction comes at the fore of the therapeutic relationship; non-formalised movement, however small, becomes the language wherein clients and therapists meet.

As psychotherapists we maintain open pathways between movements and sounds, movements and words, and welcome this expression as part of the improvised interaction with clients. We acknowledge that everyone engaging in the therapy session – therapists and clients – may, can, and should use all their skills, however different they may appear. Through de-briefing, we have realised that there is no need for therapists to 'de-skill' themselves in order to relate to clients. In other words, attuning to a client whose mobility is restricted, does not imply that therapists need to limit their movement range and vocabulary. Even though exploring and embodying clients' movement is valuable and crucial to the development of the therapeutic relationship, limiting our clinical practice to this type of interaction can be detrimental to the progress of the therapy. What we have identified is the need for therapists to be able to develop their own skilful 'dance' between attunement and honest communication through movement. Indeed, too much attunement with clients may become patronising and overpowering, whereas if therapists remain true to their full range of creative movement any movement they offer within the therapy enriches the relationship, and keeps it alive. This is comparable with two individuals communicating verbally as they bring their own story and words to an enlivened conversation.

Improvisation may develop without or with the use of touch. 'Contact Improvisation (CI) enriches the discussion on the practice of DMP with this client group, as it provides a technique whereby listening becomes an experience of the body in movement and in relation with another body through points of physical contact' (Butté, 2008).

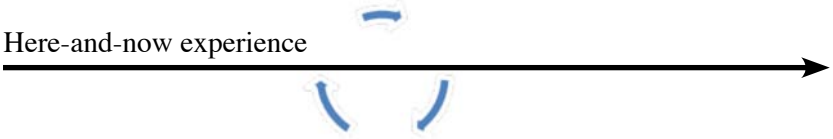
Improvisation and CI enable the DMP and his/her client with PMLD to have a dialogue through a mode of expression they are both able to engage with. Non-verbal creative expression through Improvisation and CI can then be understood as a medium for self-expression, including the expression of emotions. In this context, the disability disappears into the background and a greater sense of our shared humanity prevails; clients are able to express themselves through movement, and the use of touch becomes part of the therapeutic relationship when appropriate. The challenge for the DMP is to remain sensitive to clients' expressions and to the possibility that touch is sometimes not welcome. Being present with clients in the moment-to-moment interaction, the DMP

allows the pathway between his/her embodied self and cognitive self to remain open, informing the therapeutic relationship accordingly; thus bridging the gap between the dance technique and psychotherapy, between creative movement expression and growing self-awareness as it develops through the psychotherapeutic relationship (Butté, 2008).

Containment & Self-Reflection

We identify our experience with Yalom's self-reflective loop and Keleman's formative process. Both these theorists show the therapeutic process as moving through life experience, followed by time to reflect or to contain one-self in order to integrate personal process; echoing the continual personal process of growth through experience. This self-reflective loop provides containment, an internal locus of control (Meekums 2005: p55) in which therapeutic processes (Yalom 1985: p137) can be integrated into one's life experience. Containment and integration may be viewed as a personally embodied boundary. As this personal boundary develops, we are more able to digest the experience (Keleman 1981: p46), distinguishing between a personal world and an outer world, digesting the experience of the I and the not I (Keleman 1981: p114).

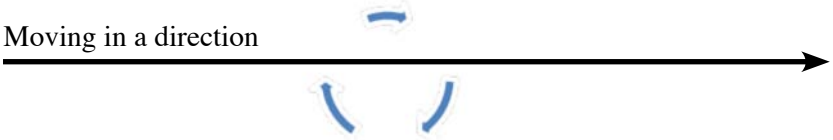
Yalom's self-reflective Process (Yalom1985: p136)



Here-and-now self-reflective loop (process)

Keleman's Formative Process (Keleman1981: p51)

Creative Void	Pre-personal Phase	Personal Phase	Post-personal Phase	Creative Void
	undifferentiated	containment	expression	
	expanding	embodiment	interaction	
	excitation		new reality	



Containing Capsule

Within this reflective/formative process we may feel some helplessness and suffer pain or mental discomfort. We may also experience uneasiness and unknowing. However we may also feel the flowing excitement of re-organising ourselves. This is the creative void in which we work, not the pit of hell. It is not a place of inner misery and deadness, but a place of inner listening and alertness in which we can assimilate old and new perceptions (Keleman 1981: p64). Within the creative void we can re-shape the experience before moving forward again.

'We steep ourselves in our environment; then we separate out, assimilate, and reflect on what has taken place. This is how we nourish ourselves, how we deepen and broaden our experiencing' (Keleman 1981: p115).

Fitting in – explore, discover, experience and understand

Our intent is for clients and therapists to meet in mutual interaction, engaging in the moment free from inhibitions or pre-conceptions. We ask the reader to be mindful of our 'being the other' in our work with this client group. We consider that the clients, our hosts, are the norm, and that we are foreigners from another culture. In the therapeutic relationship we seek to explore, discover, and experience the clients' world. As explorers journeying (Kvale 1996: p4) through our clients' embodied world we seek to understand their culture, learn their language, their rituals and their ways of moving. We may not be in complete 'harmony with those around us. But it does mean not having a sense of being an intrusive alien' (Shotter 1994: p40). From this position we are more able to experientially question established social practices, structures or power relations (Burr 2004: p123).

Positioning ourselves as group members with our own learning and physical disabilities, we have reflected on our need to 'fit in' and how we have co-created a framework which supports our work with non-verbal clients. As co-therapists we habitually warm-up and debrief together verbally and non-verbally; over time this has deepened our co-working relationship. This time dedicated for discussion and moving together has cultivated greater intuitive attunement with therapeutic interventions, which allows each of us, therapists and clients, to trust the moment and each other so that we are more frequently able to experience moments when our disabilities disappear.

Reflective practice allows us to shift position, which provides 'rich possibilities for reflecting on current choices and new opportunities for growth and change' (Parker & Best 2005: p4). Our reflective practice allows a shift from embodied to cognitive meaning giving; thus incorporating a variety of expressive and communicative channels (Soth 2006: p129) essential to movement discourse with PMLD clients. Being more aware of the positions we offer, and of the positions we are being offered in our interactions with clients, promotes the possibility of change (Burr 2004: p124). Reflecting on an embodied therapeutic encounter; from a first person position, a '2nd position – 'walking in the other person's shoes'; 3rd position – 'looking back at both 1st and 2nd positions from a distance'; 4th position – 'taking a helicopter view of all positions' (Parker and Best 2004: p8), provides a wealth of material to consider in the therapeutic space.

Shaping Personal Space

The non-verbal clients we refer to are those generally restricted to being in a wheelchair, without the means to manoeuvre themselves to suit all their needs. These chairs are expertly designed to support individual shapes in an upright position while limiting the detrimental effects of habitual twisting, slumping or slipping. For those not disabled these chairs may facilitate easier social integration though it does little to enhance PMLD clients' personal movement expression. In therapeutic sessions our preference is to work with clients out of their chairs, either sitting or lying in bean bags. This allows clients to connect with their needs, images and rhythmic actions which comprise our physical-psychic processes (Keleman 1975: p58) and lead to grounding one-self within the here and now.

Providing clients the opportunity to inhabit a different body relationship from the common wheelchair posture

allows creative exploration of their physical space and shape. Through movement expression clients are able to rhythmically expand into the environment or to contract into a more personal space. These expressions create impressions on the environment, thus expanding into relationship with others; alternatively the environment makes impressions on us (Keleman 1975: p81). This impress-ive relationship influences how we are perceived in the social environment in which we are immersed; resulting in mutual reshaping of our space and relationships, expanding or contracting depending on power discrepancies. The ebb and flow of expansion and contraction between self and others in the environment is akin to 'Interactional Shaping' (Best 2003: p8).

Inertia, Coercion or Volition

As DMPs we aim to offer clients opportunities for interaction and constructive communication. Adults with PMLD may have spent many hours alone without stimulus or cause for relating to their environment. This deficiency in worldly intrigue, through which we all learn, often leads to an inert posture. Inertia may be a default response, or a constructive choice, as a way of finding stimulation, rest or separation from external stimuli (Sherborne 2001: p91). Inertia may also be the result of negative responses to previous verbal or non-verbal expression, where emotional self-expression may have been misinterpreted by others. Expansion and contraction are integral to our biological needs, so providing the stimulation to expand (inhale) into the space and then to contract (exhale) is our intent. If the rhythm of expansion and contraction are inhibited then we are debilitated physically, emotionally, and cognitively (Keleman 1981: p79). While honouring each client's personal needs and considering the need for stimulus, it is a challenge to decide between letting clients remain inert or to coerce them toward interaction. It is a very delicate line between coercion and stimulation to encourage interaction of one's own volition. Coercing clients with PMLD toward interaction and improvised self-expression may be viewed as a 'countercultural act' (Bonefant 2006: p121).

PMLD clients may not have been exposed to the means of communication that are integral to us as movement psychotherapists. Opening a space within which clients can just be themselves is dissimilar to leaving clients in a state of inertia. We see inertia as an embodied response to not having developed the resources to interact more effectively; to respond to and engage with the world more dynamically and creatively. For example, a habitually inert client may push the therapist away after light or weighted touch on the clients' shoulders. This touch may incorporate manipulation (coercion) of the shoulder muscles and skeletal structure. This coercion stimulates the muscular cells which leads to improved pulsation (Keleman 1981: p35) in the blood flow and a subsequent shift in posture; usually to sitting more upright followed by a release of breath. Once a clients' position has shifted and the breath has been released, requests for further interaction are expressed through reaching out (volition) into the space. Volition may also be viewed as agency (Shotter 1994: p121), whereby we are 'interested in finding ways for individuals to use their agency to adjust society' (Bonefant 2006: p121).

Conclusion

Beginning with the assumption that socially, our sense of identity is located within the body, we have introduced our client group, adults with Profound and Multiple Learning Disability, and presented Social-Constructionism as the theoretical framework which underpins our practice. Our reflection has led us to consider the need for self-care and letting go of our identity and role as therapists after each session. Reflecting back into the therapy room we have introduced our main movement practice – improvisation – as a communication tool for the DMP working with Adults with PMLD. Discussing identity, we have considered further theory which enables us to think about the DMP relationship with Adults with PMLD as part of a dynamic cyclical process, within which

creativity is understood as a means to explore, discover, experience, understand and transform. Considering 'disabilities' from a different position, we have named our own disabilities as practitioners with this client group and reflected on our need to 'fit in'. Working with adults with PMLD also poses questions of mobility so we have shared an aspect of our practice where we offer clients the opportunity to experience being out of their wheelchair in order to experience themselves, and others, from a different position. Finally, we have explored self-expression and our role as therapists working with adults who may present themselves in states of inertia; with coercion and volition being some of the controversial themes raised when working with adults with PMLD. This reflection has highlighted the challenges that lie in our response-ability[1] towards our clients' well-being, sense of self and opportunities for growth.

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1 Writing 'response-ability', our intention is to invite the reader to consider the etymological root of the word 'responsibility' and be reminded that the origins of the word 'responsibility' lie in 'our ability to respond'.

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Dancing Dialogues

Following recent contributions into the relationship between music and dance in DMP, I'd like to alert you to an article published in 'The Arts in Psychotherapy' written by one of our senior registered members, Zelide Jeppe.

Zelide Jeppe was awarded Senior registration as a Dance Movement Therapist (SrDMT) in 2008. During the past 10 years, Zelide has worked with diverse client groups and individuals in a variety of contexts in the UK and, periodically, in a village on the East coast of South Africa for the Keiskamma Arts project. The project draws on the arts to address some of the problems of unemployment, boredom, alcoholism, and HIV/Aids afflicting many people in that part of the country. A TV documentary about Zelide's work in this African context, to be broadcast later this year, was recently made by Free Range Films for the *Trailblazers* series of the South African Broadcasting Corporation (SABC).

Whilst working with people in a mental health setting in London, Zelide developed a new integrative arts model. Her paper on the subject, "*Dance movement and music in improvisational concert: A model for psychotherapy"*, was published in 2006 in *The Arts in Psychotherapy* 33, Issue 5, pp. 371-382. It was listed for the period October 2006 - March 2007 as one of AIP's Top 25 Hottest Articles.

The Abstract of the article appears in this Summer issue of *e-motion*. The full article is available online on ScienceDirect at http://dx.doi.org/10.1016/j.aip.2006.06.001. Subscribers (either via their institutional access, or personal access) can link through to full text; non-subscribers have a Pay-Per-View option for full text.

'Dance movement and music in improvisational concert: A model for psychotherapy'

Zelide Jeppe

The Arts in Psychotherapy
Volume 33, Issue 5, 2006, Pages 371-382

Abstract

Improvised dance and live music played by the participants themselves define a dance/movement and music (DMM) model in which interactive, variable geometries of sound and movement open up a novel theatre for emergent imagination and drive the interplay of intra-psychic and interpersonal domains. The model is conceived as a mixture of therapeutic and artistic exploration leading to performances prepared mainly by the participants. It incorporates poetry. One outcome of the model's optional modalities is the "holding" of the dancer by the music; another is the musical instrument as a transitional object. The expanded therapeutic

environment derives strength from the non-verbal movement-and-music coupling, which may favour access to pre-verbal and unconscious psychic provenances, and from the potent triadic formation of therapist, dancers and musicians. It contributes to participants' freeing themselves from their isolation and, more generally, offers a new prospect to the expression of unresolved trauma and distress.

Keywords: Interactive; Dance; Movement; Music; Artistic; Shaping; Performance

Article Outline

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Helen Poynor

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Helen Poynor

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Price: £65

Time: Arrival: 9.45am Start: 10am – 1pm
Lunch (not provided) 1pm – 2pm
Afternoon start: 2pm – 4pm

Venue: Siobhan Davies Studios, 85 St George's Road, London SE1 6ER (Tel: 0207 091 9650)
Nearest Tube: Elephant and Castle

Adopting Supervisory Perspectives

This workshop is aimed at senior practitioners who may be acting as supervisors for others, either privately as SrDMP or within clinical settings perhaps as RDMP/SrDMP. Participants may have become supervisors by chance, perhaps by having very specific expertise, by being in the right place at the right time, or they may have additional qualifications as a verbal therapist. They may not have had a chance to look at the identity shifts, dilemmas, and joys of taking on a supervisory role or supervisory perspective. There may be others with a wealth of clinical experience who are considering becoming a supervisor.
ADMP will soon be adopting a similar route to becoming a supervisor as in other arts therapies - that of requiring a specific training. This workshop will provide space for creative exploration and sharing of issues, as well as time to discuss different supervisory models and approaches. In what ways do DMP supervisors involve movement, their own or that of supervisees? What is the effect of adopting one psychotherapeutic stance rather than another? How does one set a ethical contract? How does one deal with somatic transference and parallel processes as supervisor? What is the balance between aesthetic and psychological material? These are some of the issues to be addressed.

Workshop Leader Information:
Penelope Best is an Honorary Fellow ADMP UK; President of the European Network for Dance Movement Psychotherapy (DMP); Programme Coordinator of DMP postgraduate training in Warsaw, Poland, and core staff on Masters DMP, Rotterdam; private supervisory practice with groups and individuals, as well as international conflict resolution experience of working with multi-disciplinary teams and co-workers. Consultant researcher within educational projects on creativity. Previous programme convener of DMP programmes at Roehampton University 1992-2002 alongside the inimitable Gabrielle Parker.
For the past 11 years Penny has been researching and developing a model of supervision RCPM (Relational Creative Processes Mode*) which assists professionals to consider issues of identity, interactional shaping, and accountability. The model locates at its centre ideas of co-creation and reflexivity on both verbal and non verbal aesthetic processes. It could provide a useful starting point for promoting critical reflections upon other supervisory models and stances which take into account psychodynamic, systemic, social constructionist and narrative perspectives.
*See Best, P. (2008) Interactive reflections: Moving between modes of expression as a model of supervision. In Payne, H. (ed.) Supervision of Dance Movement Psychotherapy. London: Routledge

These Workshops are coordinated and overseen by Tracey French SrDMP

Please book in advance to avoid disappointment on the day:
Please send a cheque made payable to ADMP-UK: The Administrator, ADMP workshops, 32 Meadfoot Lane, Torquay, Devon TQ1 2BW

CPD WORKSHOP PROGRAMME 2009

Workshop Facilitator: Vaughan Titheridge, Drama Therapist

Date: Saturday 12th September 2009

Time: Arrival: 9.45am Start: 10am – 1pm
Lunch (not provided) 1pm – 2pm
Afternoon start: 2pm – 4pm

Venue: Siobhan Davies Studios, 85 St George's Road, London SE1 6ER (Tel: 0207 091 9650)
Nearest Tube: Elephant and Castle

The Body and Ritual

This workshop comes in two parts, offering participants the unique opportunity to explore the body and its connection to emotion. The second part of the day will connect our work as therapists to the therapeutic space using ritual as a key focal point.

The work of Jerzy Grotowski and his techniques of helping actors to rediscover the connection between bodies and emotions have been used for decades, through the exercises Plastiques and exercises Corporeal. The day will also look at ritual theatre and the ritual space from a practical perspective offering dance movement therapists and other therapy practitioners the opportunity to learn creative approaches to creating a safe and holding environment for the clients. We will be learning simple but effective techniques in creating ritual in the therapy space.

Workshop Leader Information:
Vaughan Titheridge is a drama therapist - team leader working in primary education and a therapeutic community. He also teaches mentors for the charity Kids Company. He has worked in an acute psychiatric day service, and clinical lead/psychiatric nurse where he co-facilitated group psychotherapy from a psychodynamic perspective. He has set up a therapy service within an inner-city school where he was team leader. Vaughan has co-facilitated workshops at The Actors Centre and East/West Centre exploring themes of the Shadow and Role Development, also connections between image, movement and emotion. He works a private drama therapist. In the past Vaughan taught Tai Chi, and Chi Kung to patients in acute psychiatric wards and the general public. He has been actively involved in dance laboratory work exploring themes of gender and identity. As well as the above he works part-time in a clinic as a Reiki practitioner.

These Workshops are coordinated and overseen by Tracey French SrDMP.

Please book in advance to avoid disappointment on the day:
We will hand out certificates of attendance on the day and this will count towards your CPD requirements.
Please send a cheque made payable to ADMP-UK: The Administrator, ADMP workshops, 32 Meadfoot Lane, Torquay, Devon TQ1 2BW

Fairy Tales in the Forest

Taking place in Sweden, in Forests, next to Lakes

A 3 day movement based workshop indoors and outdoors21st – 23rd July 2009

Weaving together voice, music, art, story making and movement

Facilitators: Maya Cockburn & Joy Kearney RDMPs

Cost: £330 Inc 4 night's full board

www.breatheinsweden.com

All Bookings to: breatheinsweden@gmail.com or info@breatheinsweden.com

A Move into Life Workshop
with Sandra Reeve PhD, SrDMP

July 8-12, 2009
Marshwood Vale, West Dorset

Strata: Autobiographical and Environmental Movement

Take 5 days to explore a life theme through movement and to resource yourself with new insights and skills. Move in many different ways, on the coast, in the woods and on a hillfort. Be held and guided as you meet yourself through movement. Create a final movement piece to crystallise your journey. *[CPD hours.]*

To book – and for details of other **Move into Life** workshops and training – visit **www.moveintolife.co.uk** or e-mail **info@moveintolife.co.uk** or call **+ 44 (0)1297 560511.**

an announcement for an upcoming workshop to be listed in Workshops and Conferences:

Authentic Movement, Witnessing the Body of Presence
with Ellen Emmet

Saturday June 20th-2 to 5 PM- £20-Synchronicity Studio:157A Huber Grove, London SW99NZ

Authentic Movement offers a space in which we move in the presence of an external witness. With eyes closed, we sense our body openly and freely, and we allow our experience to express itself completely, revealing as it does the open space of our own inner witness...

Contact ellenemmet@hotmail.com or 07791622703 for more information
www.ellenemmet.com

Advanced Training in the

Movement Psychodiagnostic Inventory (MPI)

A Correspondence Tutorial beginning May 1, 2009 and

Amsterdam Workshop September 4 - 6, 2009

Faculty
Martha Davis, Ph.D., CMA
Robyn Flaum Cruz, Ph.D., ADTR
Hedda Lausberg, Professor Dr. med.

NVDAT
Nederlandse Vereniging voor Danstherapie

***A 2009 advanced MPI training package* is being offered to clinicians and behavioral researchers such as dance/movement therapists, psychologists and psychiatrists interested in developing expertise in observation and analysis of movement patterns associated with psychopathology. Completion of an Introductory workshop to the MPI is a pre-requisite. For applicants who have not taken an Introductory workshop on the MPI, we are offering an introductory correspondence tutorial to be taken before continuing onto the 2009 Advanced MPI training program. The intro tutorial cannot be taken alone.**

The Advanced ***MPI*** training involves two components, both of which are required: a correspondence tutorial in which you receive training DVDs on the MPI to study at home, accompanied by assignment to one or more of the MPI faculty for observation assignments, questions, and discussion of the topics covered in the DVDs. This will be done through internet communications.

The correspondence tutorial must be completed before the September workshop on a schedule worked out by you and your tutor(s). We estimate that study of the DVDs should take about ***10*** hours of your time, and the tutorial communications about ***6*** hours in toto, with an additional ***10*** hours for observation and study assignments that will be tailored to your interests and experience. If you need to fulfill the pre-requisite, we estimate the introductory MPI correspondence tutorial will take an additional 8 hours.

The tutorial and DVD home study will allow us to concentrate in the workshop on observation training and attention to how the MPI may serve your individual interests and projects. On completion of the Advanced training package, you should be proficient enough in the MPI to teach it for clinical use or do observation coding on research projects that use either part of the instrument or the MPI Short Form.

Workshop Location in Amsterdam, The Netherlands to be announced.
Correspondence tutorials will begin in May

About the Faculty
Martha Davis, PH.D. is a clinical psychologist with over 40 years experience in the study of nonverbal communication. She began development of the MPI in the 1960s. Her major research interests include movement characteristics of schizophrenic patients, patient / therapist interactions in psychotherapy and behavioural cues to deception in forensic interviews. Author of several books and numerous articles on nonverbal communication, she is currently Visiting Scholar, John Jay College of Criminal Justice, City University of New York.

continued on next page

Robyn Flaum Cruz, Ph.D. is Associate Professor, Expressive Therapies Ph.D. Program, Lesley University Division of Expressive Therapies. Currently, she serves as President, American Dance Therapy Association and Editor-in-Chief of 'The Arts in Psychotherapy'. She is contributor and co-editor of 'Dance/Movement Therapies in Action: A working Guide to Research Options' (Charles C. Thomas Publishers). A research methodolgist, she has taught internationally and her work is represented in numerous juried journals spanning the areas of dance therapy, psychiatry and neurology, communications disorders and psychology.

Hedda Lausberg, Professor of Psychosomatic Medicine, Friedrich-Schiller-Universität Jena; dance therapist (BVT), specialist in neurology, psychosomatic medicine and psychotherapy, psychiatry; habilitation in neurology at the Charité - University hospital Berlin; co-founder of the Berlin Gesture Center (www.berlingesturecenter.de); has received research grants from the German Research Association, the Max Planck Society, and the Volkswagen-Stiftung. Research focuses are: development of movement analysis tools for clinical and research purposes; relation between movement behavior and mental disease. A major research project examined the movement behavior of patients with eating disorders. As a neuroscientist, her recent studies investigate the neuropsychology of movement behavior, specifically the relation between movement and cognitive and emotional processes.

Registration

MPI training is limited to mental health practitioners and students and behavioral researchers. Advanced students in these professions are also eligible.

Correspondence tutorial and workshop fee

320 Euro
280 Euro (NVDAT-reduction / students)

Contact

Monique van den Heuvel
Email: nvdat.secretaris@vaktherapie.nl
T 0031(0) 6 39147764

If you have not taken an introductory MPI workshop, you must complete the MPI introductory correspondence tutorial to qualify for the advanced training package. The fee is 50 Euro. The introductory tutorial is being offered only to fulfill the requirement for the advanced training package and cannot be taken alone.

Registration *due by April 30, 2009*

If enrollment is insufficient, the 2009 advanced training package will be canceled and your registration fee fully refunded.

Payment to

For the Netherlands:

Giro 2144180

For foreign countries:
Swiftcode: pstbnl 21 Swiftaddress:
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1000 BV Amsterdam
Iban: NL 45 pstb0002144180

t.n.v. FVB Utrecht,

o.v.v. NVDAT, MPI 2009.

Please mention: NVDAT, MPI 2009

Your enrolment will be confirmed after your payment has been received.

Therapists and Supervisors

Dr Beatrice Allegranti SrDMT, MA DMT
Offers individual and group supervision integrating Feminist and Dreambody Approaches. CPD short courses also available. Visit www.embodiedpractice.co.uk
Contact b.allegranti@roehampton.ac.uk or call 0208 392 3377.

Sara Bannerman-Haig SrDMT
North London
Tel: 07977109699
sara_haig@hotmail.com

Leah Bartal SrDMT
Offers individual DMT and Supervision including Psychosynthesis, Jungian Background, Feldenkrais and Authentic Movement. Monthly workshops include writing and mask-making. North West London and internationally.
Tel/Fax: 0207 722 9768.

Dawn Batcup, SrDMT
Offers supervision or DMT in South London using a psychodynamic perspective. Dawn's experience is in mental health across the various specialisms, including Forensics.
Contact: dawn.batcup@swlstg-tr.nhs.uk or Tel. 0208 682 6236

Catherine Beuzeboc, SRDMT
Offers individual sessions in movement psychotherapy and supervision in North London NW5. Existential / Humanistic orientation.
Tel: 0207 267 6253 or email: c.beuzeboc@btinternet.com

Penelope Best SrDMT
Offers individual and group creative process oriented supervision and consultation sessions in East London and east midlands (Milton Keynes). Contact: pbestworks@aol.com

Katya Bloom, SrDMT, CMA, MA, PhD
Offers individual movement therapy and supervision in North London.
Contact:: kbloom@talk21.com

Natasha Colbert, SrDMT
Offers supervision and individual movement psychotherapy in West London, W11. Sliding scale available.
Contact: tasha_colbert@yahoo.co.uk or Tel: 0207 229 3883

Sue Curtis, SrDMT
Available in South East London for supervision, training or workshops. Sue specialises in all aspects of work with children and young people.
Contact: Tel: 0208 244 0968 or suecurtisdmt@ntlworld.com

Juliet Diener MA SRDMP
Offers individual/ group therapy and supervision in NW or SE London .
Working using an integrative model with experience in both Mental Health and Educational settings.
Contact: juliet@icandance.co.uk 07931 533 955

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Shropshire, London
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Authentic Movement-Transpersonal perspective
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Contact ellenemmet@hotmail.com or 07791622703

Yeva Feldman, SrDMT, MSc, Gestalt Therapist in advanced training
Offers supervision (individual and group) in South West London and professional development workshops.
Contact: Tel: 07958 610234, email:
yeva.rob@gogglemail.com

Tracey French, SrDMT
Offering supervision (especially those working with adolescent client groups), and individual Dance Movement Psychotherapy. London based.
Contact: traceyfrenchdmt@yahoo.com
Tel: 07760175756

Caroline Frizell, MA, SrRDMT
North London. Supervision and training with particular reference to disability and inclusion; working with the earth in mind.
contact: frizarm@btinternet.com Tel: 07931 230257

Gerry Harrison SrDMT - available for supervision, especially for those
working in psychiatric settings.
Contact: gerryharri@hotmail.com or 07977 094 789

Linda Hartley, MA, SrDMT, BMCA, RMT, UKCP
Offers personal therapy, integrating Authentic Movement, Body-Mind Centering and a transpersonal and body-oriented approach to Psychotherapy. Supervision available in and Cambridge and Norwich.
Contact: Tel: 01799 502143 or email:
Linda@lindahartley.co.uk www.lindahartley.co.uk

Sarah Holden, BA hons, IGA, UKCP
offers individual and group movement psychotherapy, supervision. South London.
Contact: tel 07956208276 or
sarahholden@movementpsychotherapist.com

Martina Isecke SrDMT, Dance Artist, Psychologist
Creative coaching and dance holidays at Lanzarote, Canary Islands, Spain. Offers supervision, DMT workshops, dance tuition.
Contact: Tel: 0034 6805 88728 or e-mail:
tinaise@yahoo.co.uk, www.martinadance.com

Fran Lavendel, MA, SrDMT, BMC practitioner
Teacher of Authentic Movement offers movement psychotherapy, group work and supervision.
Contact: lavendelmaclean@ednet.co.uk or
Tel: 01968 676461

Helen Leake MA, MA(psych) SrDMT
Group & Individual supervision SE London. Helen is a DMT & Child & Adolescent Psychotherapist working in the NHS and Social Care.
e-mail: heleake@yahoo.co.uk or call 07742225445

Jeanette MacDonald, SrDMT, ARAD
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Dr. Bonnie Meekums SrDMT, UKCP Hon. Fellow ADMT UK
Is available for both private individual therapy and clinical supervision in the North and North West of England.
Contact: University of Leeds, Wakefield Site, Margaret Street, Wakefield WF1 2DH. or email: b.meekums@leeds.ac.uk

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Contact: anehrensomatx@yahoo.com

Nina Papadopoulos, SrDMT
Is available for individual DMT and supervision in East London.
Tel 020 85563180 or email: ninadmt@yahoo.com

Professor Helen Payne, PhD, SrDMT, Fellow ADMT-UK, UKCP
Professor Helen Payne PhD, has over 30 years experience with groups and individuals. Accredited Psychotherapist since 1992 (UKCP). Integrative approach and Authentic Movement.
Contact: Tel: 01438 833440 or email:
H.L.Payne@herts.ac.uk

Athena Pikis SrDMT.
Offers individual and group DMT and Counselling Sessions and Workshops in her country Cyprus. Also available for supervision.
Contact: Tel: (00357)22518765, (00357)99543461, address: 6 Kilkis Street, Flat 21, 1086 Nicosia, or email:
athenapiki@hotmail.com

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Sandra Reeve SrDMT
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Contact: Tel: 01297 560511 www.moveintolife.co.uk

Susan Scarth MCAT, SrDMT
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Contact: sbscarth@hotmail.com, mobile: 07962814630

Rosa Shreeves SrDMT, Dance Artist
Offers individual therapy, supervision, choreography and consultancy in West London.
Contact: Tel. 0208 995 5904 or email:
rosashreeves@rosashreeves.plus.com

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Contact: 01524 32920 or allison.singer@btinternet.com

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Karkou, V. (1999) Who? Where? What? A brief description of DMT: Results from a nationwide study in arts therapies, e-motion, ADMT UK Quarterly, XI, (2), 5-10.

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